Making a dent with corticosteroid injections for de Quervain's tenosynovitis

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Accepted 16 January 2016

DESCRIPTION

A 71-year-old patient presented with an abnormal patch of skin on the radial aspect of her right wrist (figures 1 and 2). Eighteen months previously, she had undergone an intra-tendon sheath steroid injection (0.25 mL triamcinolone 40 mg/mL) at the site, for de Quervain's tenosynovitis. In the weeks following the injection, she noticed marked indentation of the skin surrounding the injection point, followed by tenderness and a predisposition to bruising. Examination revealed an atrophic patch of skin with a central ecchymosis from mild accidental trauma. These findings would be consistent with a lipo-atrophy and dermal-atrophy.

Skin atrophy is a well-known complication of topical and systemic steroid treatment. However, atrophy from intratendon sheath injections is much less common, and may arise from leakage of the steroid preparation into the subcutaneous tissues. A related phenomenon is linear atrophy and hypopigmentation resulting from the lymphogenous spread of the steroid.[1]

Treatment options are limited. We discussed simple observation or excision of the affected area and emplacement of a full-thickness skin graft. Intradermal fillers with saline or autologous fat transplants have also been tried.[2 3]

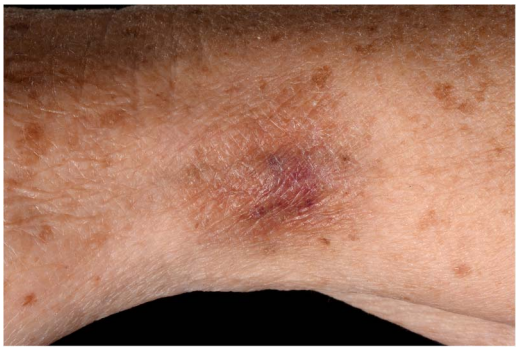

Figure 1 Medial view of atrophic skin on right wrist centred on injection point. A prominent vein is visible in the middle of this area.

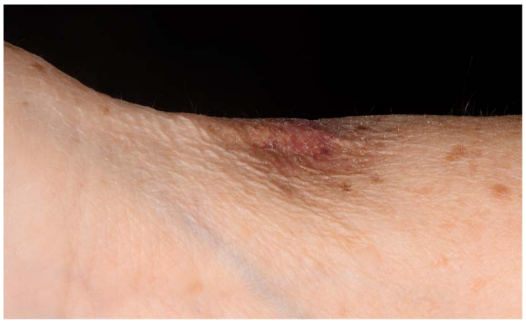

Figure 2 View of lesional skin from the anterior of the wrist demonstrating the marked indentation of the atrophic skin.

Learning points

- Skin atrophy is a potential complication of intratendon sheath steroid injections and patients should be warned of this as part of their consent process.
- Skin atrophy from intratendon sheath steroid preparations can be rapid due to the potency and persistence of the steroid in the subcutaneous tissues.
- Steroid skin atrophy is irreversible if the dermis is involved, and treatment options include observation, excision with grafting and intradermal fillers.

Contributors AK was involved in the management of the patient, and prepared the article and submitted it for publication. CEG was the overseeing consultant for the patient, was also involved in the direct management of the patient, and reviewed the manuscript prior to submission.

Competing interests None declared.

Patient consent Obtained.

Provenance and peer review Not commissioned; externally peer reviewed.

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To cite: Khoo A, Grattan CE. *BMJ Case Rep* Published online: [*please include* Day Month Year] doi:10.1136/bcr-2015-214225